Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

LOU, EUGENE C
7401 S MAIN STREET
HOUSTON TX 77030

Carrier's Austin Representative Box
01

MFDR Date Received
January 3, 2011

Respondent Name
Liberty Mutual Insurance Co

MFDR Tracking Number
M4-11-1993-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: …29824 was done to the clavicle – a piece of bone was removed from this bone."

Amount in Dispute: $1,226.02

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The bill and documentation attached to the medical dispute have been re-reviewed and our position remains unchanged."

Response required from: Liberty Mutual

SUMMARY OF FINDINGS

Disputed Dates	Disputed Services	Amount In Dispute	Amount Due
April 23, 2010	29824	$1,226.02	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. Former 28 Texas Administrative Code, §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.203(b)(1) sets out medical bill submission requirements for health care providers.
3. 28 Texas Administrative Code §134.203(c)1 sets out fee guidelines for professional medical services.
4. 28 Texas Administrative Code §133.4 requires written notification to health care providers regarding contractual agreements for informal and voluntary networks.
5. 28 Texas Administrative Code §102.4 sets out general rules regarding communications.
6. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - Z547 – THIS BILL WAS REVIEWED IN ACCORDANCE WITH YOUR FEE FOR SERVICE CONTRACT WITH FIRST HEALTH.

- X901 – DOCUMENTATION DOES NOT SUPPORT LEVEL OF SERVICE BILLED.
- U849 – THIS MULTIPLE PROCEDURE WAS REDUCED 50% ACCORDING TO FEE SCHEDULE OR USUAL AND CUSTOMARY GUIDELINES.
- B291 – THIS IS A BUNDLED OR NON COVERED PROCEDURE BASED ON MEDICARE GUIDELINES; NO SEPARATE PAYMENT ALLOWED.

Issues

1. Are the disputed services subject to a contractual agreement between the parties to this dispute?
2. Is the level of service supported by documentation?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier reduced or denied disputed services with reason code Z547 – "THIS BILL WAS REVIEWED IN ACCORDANCE WITH YOUR FEE FOR SERVICE CONTRACT WITH FIRST HEALTH." Review of the submitted information found insufficient documentation to support that the disputed services were subject to a contractual fee arrangement between the parties to this dispute. Nevertheless, on March 15, 2011, the Division requested the respondent to provide a copy of the referenced contract as well as documentation to support notification to the healthcare provider, as required by 28 Texas Administrative Code §133.4, that the insurance carrier had been given access to the contracted fee arrangement. Review of the submitted information finds that the documentation does not support notification to the healthcare provider in the time and manner required. The Division concludes that, pursuant to §133.4(g), the insurance carrier is not entitled to pay the health care provider at a contracted fee. Consequently, per §133.4(h), the disputed services will be reviewed for payment in accordance with applicable Division rules and fee guidelines.

2. 28 Texas Administrative Code §134.20(b)(1) states, in pertinent part, "for coding, billing reporting, and reimbursement of professional medical services, Texas Workers' Compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; … and other payment policies in effect on the date a service is provided…" The medical bill for the service in dispute included American Medical Association Current Procedural Terminology (AMA CPT) code 29824. Documentation should support removal of 8-10mm from the distal clavicle/joint to qualify for reimbursement of distal claviculectomy. The medical documentation including the document titled "Operative Report" was reviewed but documentation requirements were not met. Therefore, no additional reimbursement can be recommended.

3. 28 Texas Administrative Code §134.203(c) states in pertinent part, "To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications. (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $54.32. … Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year." The calculations of MAR are as follows:

Code	MAR Calculation	Units	Allowable
23410	(54.32 / 36.0791) x 802.52	1	$1,208.26
29824	Not supported	1	$ 0.00
29826	(54.32 / 36.0791) x 650.15 subject to 50% multiple procedure reduction	1	$ 489.43
	Total		$1,697.69

4. The total allowable for the disputed charges is $1,697.69. The carrier paid $2,131.17. No additional reimbursement can be recommended.

Conclusion

For the reason stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031 the Division has determined that requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		December 4, 2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.